

New national investigation of mental health-related homicides in England

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The Nottingham Inquiry (England) examined the 2023 killing of three members of the public and the serious injury of three others by a person with schizophrenia who had a history of contact with mental health services. The Nottingham Inquiry, whose evidence hearings concluded on June 5, 2026, explored in detail the clinical decisions and policy priorities that preceded this tragedy. It placed a renewed focus on public safety in mental health to which a system-wide response will be vital. The National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH) at the University of Manchester (Manchester, UK) will recommence data collection on homicides committed by patients under mental health services in England¹ - this work was decommissioned in 2018. The word “homicide” has been restored to the NCISH name; this new homicide investigation will examine issues highlighted by evidence heard during the Nottingham Inquiry: the response by clinical staff to warning signs such as the committing of previous acts of violence; treatment refusal and loss of contact with mental health services; risk assessment; use of the Mental Health Act; collaboration between agencies such as the police and mental health services; and outcome in court. A priority will be patients in contact with mental health services with severe mental illnesses such as schizophrenia. NCISH will also study homicides by people who were formerly patients or who had never been in contact with services.

Additional areas for investigation will reflect other high-profile incidents²⁻⁴ and will include people with autism, domestic abuse, young or vulnerable victims, terrorist motives, links to the UK Government’s Prevent programme,⁵ and immigration status. These sensitive issues are already part of a wider discourse on mental illness and homicide and evidence is needed to examine the interplay between them. NCISH will aim to work with victims’ families, incorporate their questions into our data collection, and publish findings regularly to ensure that professionals and the public remain informed.

NCISH was established in Manchester in 1996 at a time when the policy of community care was under scrutiny after several serious incidents, notably the killing of Jonathan Zito by a patient with

schizophrenia. Following a public inquiry and the 1994 Ritchie Report,⁶ assertive outreach teams, designed to keep in contact with patients who might otherwise lose contact with services, were established across England. In 2007 the Mental Health Act was amended to introduce compulsory treatment in the community for some previously detained patients when it is judged clinically necessary for their health, safety, or public protection.

There is no single answer to the question of how many homicides are committed by people with mental illness. NCISH will set out figures for perpetrators and victims, individuals with recent or previous contact with services, by current or past disorder, and by diagnosis. Most will be identified by outcome in court but we will aim to understand why some suspected cases do not lead to conviction.

The variation in these figures is substantial. In the final estimates from our previous homicide work, covering 2006-16, we reported an average of 55 homicides by recent patients (had been in contact with mental health services within the last 12 months) and 58 victims on average per year in England⁷ including anyone with a history of mental disorder at any time raises this number to well over 100.⁸ However, this broader definition also reduces the proportion with severe mental illness, encompassing people with, for example, drug dependence or personality disorder - far removed from our core remit of homicides under community mental health care. Furthermore, if someone is a recent patient, it does not in itself indicate the presence of severe mental illness. Of the 55 homicides committed by recent patients in England, around 20 had schizophrenia, although the figure for this diagnosis is over 30 when former patients and those who have never been in contact with services are added.⁷

NCISH will continue to report figures for patients who for any reason are not receiving care as intended, a critical issue in the Nottingham Inquiry as it was in the Ritchie Report. We found that around half of homicides by mental health patients in England were preceded by treatment refusal or loss of contact with services.⁹ In another study, 94% of patients with schizophrenia who committed homicide in England and Wales were found either to be not in receipt of care as planned or to have a history of alcohol or drug misuse.¹⁰ Addressing these factors is key to future prevention.

The Nottingham Inquiry is likely to have a profound effect on mental health priorities, the culture of care, and the essential responsibility of mental health professionals for public safety. Yet the past 30 years show that the effect on services of even the most distressing events can fade over time.

Preventing this from happening again will take evidence, professional leadership, and an honest dialogue about risk with bereaved families and a wary public.

Competing Interests

NK works with National Health Service (NHS) England on national quality improvement initiatives for suicide and self-harm; is an advisory group member for the Department of Health and Social Care (DHSC) National Suicide Prevention Strategy Advisory Group for England; has been a committee member for guideline groups for the National Institute for Health and Clinical Excellence

(NICE); and reports grants from the DHSC, the National Institute for Health and Care Research (NIHR), and the Healthcare Quality Improvement Partnership (HQIP); and is supported by Mersey Care NHS Foundation Trust and the NIHR Greater Manchester Patient Safety Research Collaboration (NIHR204295). LA chairs the DHSC National Suicide Prevention Strategy Advisory Group; and reports grants from HQIP, NHS England, the Department for Education, and the Medical Research Council. PT reports grants from HQIP, NIHR, and Gambling Research Exchange Ontario. All other authors declare no competing interests. The National Confidential Inquiry into Suicide, Homicide, and Safety in Mental Health is commissioned by the HQIP as part of the National Clinical Audit (NCA) and Patient Outcomes Programme (HQIP NCA 2069, Mental Health Clinical Outcome Review Programme). All researchers are independent from the funders.

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